TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DOCTOR'S HOSPITAL AT RENAISSANCE

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-1977-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $1,062.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the hospital NCCI edit shows code 96374 is comprehended to code 29881 unless a modifier is applied. . . . Review of the bill shows none. . . . Codes 94640 and 51798 have status indicator Q1. . . The 2016 OPPS Addendum D1 states "Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator 'S,' 'T,' or 'V.' . . . Code 29881 has status indicator T. . . . Thus, no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2016 to November 30, 2016	Outpatient Hospital Services	$1,062.12	$10.64

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 236 – THIS BILLING CODE IS NOT COMPATIBLE WITH ANOTHER BILLING CODE PROVIDED ON THE SAME DAY ACCORDING TO NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
   - 616 – THIS CODE HAS A STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER APC CODES THAT HAVE BEEN IDENTIFIED BY CMS.
   - 617 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE
   - 725 – APPROVED NON NETWORK PROVIDER FOR TEXAS STAR NETWORK CLAIMANT PER RULE 1305.153 (C).
   - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G).
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.]
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 370 – THIS HOTPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds separate reimbursement for implantables was not requested.

2. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov. Reimbursement for the disputed services is calculated as follows:

   - Procedure codes 36415, 80051, 82962 and 85027 have status indicator Q4, denoting packaged labs. Separate payment allowed at Clinical Laboratory Fee Schedule rates if the bill contains only status Q4 HCPCS codes listed in the CLFS; otherwise, payment for these labs is included with reimbursement for the primary service(s).

- Procedure code 29881 has status indicator T, denoting significant outpatient procedures paid by APC. This is assigned APC 5122. The OPPS Addendum A payment rate is $2,395.59. This is multiplied by 60% for an unadjusted labor-related amount of $1,437.35, which is multiplied by the facility's wage index of 0.8026 for an adjusted labor amount of $1,153.62. The non-labor related portion is 40% of the APC rate, or $958.24. The sum of the labor and non-labor portions is the Medicare facility specific amount of $2,111.86. This is multiplied by 200% for a MAR of $4,223.72.
- Procedure codes 94640 and 51798 have status indicator Q1, denoting STV-packaged codes — reimbursement is included in the package for any procedure with status indicator S, T or V; these codes is not separately payable unless no other status S, T or V code is billed the same day. Reimbursement for these services is included with payment for procedure code 29881. Separate payment is not recommended.
- Procedure codes J2250, J2765, J3010, J1885, J2405, J2370, J0690 and J0330 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code A9270 has status indicator E, denoting excluded or non-covered codes—not payable on an outpatient bill. Payment is not recommended.
- Per Medicare policy regarding CCI edits, procedure code 96374 may not be reported with procedure code 29881 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure. Separate payment is not recommended.

3. The total recommended reimbursement for the disputed services is $4,223.72. The insurance carrier has paid $4,213.08 leaving an amount due to the requestor of $10.64. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $10.64.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $10.64, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 24, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.